

FILED FEB 10 1945

Registration District No. 142

Primary Registration District No. 5-5-56

State File No. _____

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Howell County
 (b) City or town Mountain View, Mo Rural
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Golda Henry camp
 None
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution No
 (Specify whether
 In this community 25 Years
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shannon 101
 (c) City or town Rural Mountain View, Mo 0
 (If outside city or town limits, write "RURAL") 0
 (d) Street No. _____
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME

Rosa J. Hays

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 3 Divorced
 6. (b) Name of husband or wife Henry Hays 6. (c) Age of husband or wife if alive 1882 years
 7. Birth date of deceased April 2nd (Month) (Day) (Year)

8. AGE: Years 62 Months 9 Days 20 If less than one day _____ hr. _____ min.

9. Birthplace Shannon Co Missouri (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER

12. Name G. W. McClellan
 13. Birthplace Alabama (City, town, or county) (State or foreign country)
 14. Maiden name Nancy McCurdy
 15. Birthplace Alabama (City, town, or county) (State or foreign country)

16. (a) Informant Hazel Yankee
 (b) Address Mountain view, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 27th (Month) (Day) (Year)

(c) Place: burial or cremation Mtn. View Cem.

18. (a) Signature of funeral director John L. Duncan

(b) Address Mountain View, Mo

19. (a) 2-8-45 (Date received local registrar) (b) Auth Hunt (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 22nd year 1945 hour 12 minute 30 AM.

21. I hereby certify that I attended the deceased from _____, 19____, to Death - 22-45, 1945, that I last saw her alive on Jan-18-45 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy
 Due to Senility
 Due to 83a
 Other conditions (Include pregnancy within 3 months of death) _____

Duration

PHYSICIAN

Major findings: Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? (City or town) (County) (State) _____
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____
 While at work: _____ (c) Means of injury 0

23. Signature [Signature] (M. D. brother)
 Address Mtn. View Mo Date signed 2-8-45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Registered Apprentice No. _____

Signed _____

Licensed Embalmer No. 2516

P. O. Address Miss View No.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb
Registrar's No. 3

Registration District No. 142 Primary Registration District No. 65

1. PLACE OF DEATH:
(a) County Hauell
(b) City or town Rural - Goldsberry
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days
3. (a) PRINT FULL NAME Rosa J. Hays
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 2
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 2 (Month) (Day) (Year)

8. AGE: Years 62 Months 9 Days 1 (Unless than one day) min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 2 year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

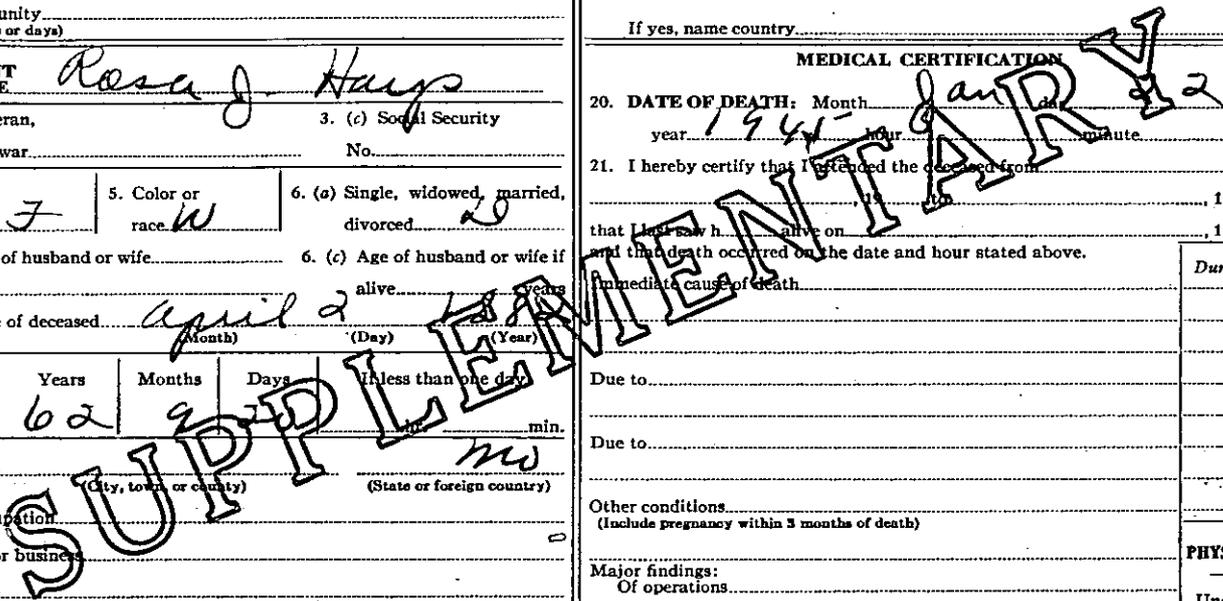
Major findings:
Of operations _____
Of autopsy _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD



5-10-11